

Barrier Screening Tool

© Copyright 2002 State of Wisconsin
Department of Workforce Development.
All rights for the commercial use of these
materials are reserved.



State of Wisconsin
Department of Workforce Development
January 2003

<http://www.dwd.state.wi.us>

WISCONSIN DEPARTMENT OF WORKFORCE DEVELOPMENT

The Functional Screen

Note to Interviewer: The W-2 Barrier Screening Tool Agreement must be reviewed with the participant and signed before you begin.

Interviewer narrative: *First, I have questions about your ability to get around.*

A. Mobility	All of the time	Most of the time	Some of the time	None of the time
A1. Are you experiencing any problems walking fast or walking long distances?				
A2. Do you need help from either a person or a device (for example a cane or a walker) to walk and/or drive a car?				
A3. Do you need help to get around in the community?				
If answer to A3. is "All of the time" or "Most of the time," ask for explanation: <i>"Please explain what type of help do you need and why"</i>	<hr/> <hr/>			

Interviewer: If the response to any of the above questions is "All of the time," or "Most of the time," follow up by asking: "Will this condition cause any problems with your participation in work or work training? If yes, "Please tell me how." Write in response below:

Referral Information: Refer to a physician, or DVR or a private vocational rehabilitation agency if information given indicates that the condition may affect her or his ability to work or to take part in a job training program.

Interviewer narrative : *This next set of questions asks about your physical abilities.*

B. PHYSICAL DEMANDS	All of the time	Most of the time	Some of the time	None of the time
B1. <i>Do you have problems standing or sitting for long periods of time?</i>				
B2. <i>Do you have problems bending, stooping or squatting?</i>				
B3. <i>Do you have any difficulties lifting?</i>				
B4. <i>Do you have difficulties climbing or keeping your balance?</i>				

Interviewer: If the response to any of the above questions is "All of the time," or "Most of the time," follow up by asking: *"Will this condition cause any problems with your participation in work or work training? If yes, "Please tell me how."* Write in response below:

Referral Information: Refer to a physician, or DVR or a private vocational rehabilitation agency if information given indicates that the condition may affect her or his ability to work or to take part in a job training program.

Interviewer Narrative: *The next three questions have to do with your sensitivity to smells, noise and temperature.*

C. ENVIRONMENTAL CONDITIONS	Yes	No
C1. Are you allergic to any dust, fumes or smells?		

Interviewer: If the response is "Yes," follow up by asking: "Will this condition cause any problems with your participation in work or work training? If yes, "Please tell me how." Write in response below:

C. ENVIRONMENTAL CONDITIONS	All of the time	Most of the time	Some of the time	None of the time
C2. Are you having trouble with noise or vibrations?				

Interviewer: If answer is "All of the time," or "Most of the time," ask for more information; "Give me examples of the ways in which you have trouble with noise and vibrations":

C. ENVIRONMENTAL CONDITIONS	All of the time	Most of the time	Some of the time	None of the time
C3. Do you have difficulties with extreme temperatures?				

Interviewer: If answer is "All of the time," or "Most of the time," ask for more information; "Give me examples of the ways in which you have trouble with extreme temperatures."

Referral Information: Refer to a physician, or DVR or a private vocational rehabilitation agency if information given indicates that the condition may affect her or his ability to work or to take part in a job training program.

Interviewer Narrative: *Next, I am going to ask you questions about being able to function independently, without help.*

D. SELF CARE	All of the time	Most of the time	Some of the time	None of the time
D1. <i>Do you have problems cooking, shopping, or performing other household chores by yourself?</i>				
D2. <i>Do you need assistance handling money?</i>				
D3. <i>Do you forget or need reminders to pay bills on time or keep track of appointments?</i>				
D4. <i>Do you have difficulty remembering what you have just been told, or what you heard recently?</i>				

Referral Information: Refer for Screen 2 if answer to any of the questions is “All of the time” or “Most of the time”.

Interviewer Narrative: *We are more than halfway through the screen. The next set of questions is about how you interact with people.*

E. COMMUNICATIONS	All of the time	Most of the time	Some of the time	None of the time
E1. <i>Do people have trouble understanding what you say?</i>				
E2. <i>Do you have trouble explaining to others what you want or need?</i>				
E3. <i>Do you have difficulty understanding or remembering what you read?</i>				
E4. <i>Do you have difficulty expressing yourself in writing?</i>				
E5. <i>Do you have trouble concentrating on work?</i>				

Referral Information: Refer for Screen 2 if answer to any of the questions is “All of the time” or “Most of the time.”

F. SOCIAL SKILLS	All of the time	Most of the time	Some of the time	None of the time
F1. <i>Do you feel uncomfortable around other people, in crowds or in unfamiliar places?</i>				
F2. <i>Do you get angry or frustrated easily? Or, has anyone else ever told you that you get angry or frustrated easily?</i>				
F3. <i>Do you have trouble taking directions from a supervisor?</i>				
F4. <i>Do you have trouble asking for help when you are having a difficult time with tasks?</i>				

Referral Information: Refer for Screen 2 if answer to any of the questions is “All of the time” or “Most of the time.”

Interviewer Narrative: We are almost done with the screening. The remaining questions require a "Yes" or "No" answer, and we should be able to get through all of them quickly.

G. WORK LIMITATIONS	Yes	No
G1. Do you have any medical problems (e.g., diabetes, epilepsy /seizures, heart disease, TB)		
If yes, "Please tell me what medical problems you are having:"	<hr/> <hr/> <hr/> <hr/> <hr/>	

Interviewer: If medical condition is identified, follow up by asking:
 "Will this condition cause any problems with your participation in work or work activities?" If yes,
 "Please tell me how." Write in response below:

Referral Information for G1: Refer to a physician, or DVR or a private vocational rehabilitation agency if information given indicates that the condition may affect her or his ability to work, or to take part in a job training program.

G. WORK LIMITATIONS	Yes	No
G2. Are you currently having problems with:		
a. Alcohol or drug use Referral Information for G2a: Refer to AODA service provider for assessment if answer is "Yes."		
b. Anxiety Referral Information for G2b: Refer for Screen 2 if answer is "Yes."		
c. Depression Referral Information for G2c: Refer for Screen 2 if answer is "Yes."		
G3. When you were in school did you ever find yourself falling behind and needing extra help with learning? Or, Were you ever in special education classes? Referral Information for G3: Refer for Screen 2 if answer to either question is "Yes."		

Interviewer Comments: *Is there any thing else that I have not covered that you think would be important for me to know?*

Interviewer Narrative: *Thank you for taking the time to do this screen.*

Domestic Abuse Screen Interviewer Version

Interviewer Narrative: *Because so many people are harmed by domestic abuse we ask the following questions of everyone who comes to us for assistance. These questions will help us find out how best to serve you and connect you with services that you need. The information you share about yourself through this screen will be kept confidential.*

If you're uncomfortable with answering any of the questions about domestic abuse, let me know and we'll move on to the next question or you can ask to stop the interview. You will not be penalized in any way for the way you answer the questions.

If you prefer, I can find a quiet spot where you can sit down and answer the questions on your own.

Note to Interviewer: The questions below refer to a relationship between the participant and a "partner." Please explain the following to the participant. For purposes of the screen "partner" can include any of the following: a spouse or former spouse, an adult with whom the individual has or had a dating relationship, an adult with whom the person has a child in common, an adult or minor family member, or an adult or minor with whom the person resides or formerly resided. This is to acknowledge the broad circumstances in which domestic abuse can occur.

	Question	Yes (if yes, when)		No
		Current	Past	
1	<i>Have you been in a relationship in which your partner has harmed you either physically or sexually? (Examples: punching, grabbing, pushing, choking, restraining)</i>			
2	<i>Have you ever been afraid that your partner might hurt you? (Examples: using looks, actions, gestures, smashing things, destroying property, abusing pets, displaying weapons)</i>			
3	<i>Has your partner made threats to physically harm you?</i>			
4	<i>Has your partner ever prevented you from leaving your home, traveling to work, or visiting family or friends?</i>			
5	<i>Has your partner ever refused to let you have money, made you ask for money, or took money from you against your will?</i>			
6	<i>Have you ever received services or lived in a shelter for victims of domestic abuse?</i>			

Interviewer Narrative: *Thank you for your patience and cooperation.*

Referral Information: One or more “yes” answers (in either current or past relationship) may indicate the need to refer participant to local domestic abuse services for safety planning, counseling or housing needs. A referral to a local domestic abuse agency may be made as a result of how the participant responded to the screen **or** as a result of your informal observations and discussions with the participant. Follow through on the referral is not mandatory for the participant. S/he will choose whether or not to access the services depending on her/his situation.

Note to Interviewer: Regardless of how the participant answered the screen, please share with her/him pamphlets and brochures offering information on the issue of domestic abuse and about the local agencies that offer domestic abuse services. The participant may choose not to take the pamphlets and brochures with them, as doing so may endanger them; therefore, this decision should be respected.

Good Cause Claim: At this time, depending on the screen outcome, it may be appropriate to review the Good Cause Claim form which explains how to claim good cause for not cooperating with child support.

Domestic Abuse Screen (Self-Administered Version)

Domestic Abuse Screen Self-Administered Version

Introduction

Because so many people are harmed by domestic abuse we ask the following questions of everyone who comes to us for assistance. These questions will help us find out how best to serve you and connect you with services that you need. The information you share about yourself through this screen will be kept confidential.

If you're uncomfortable with answering any of the questions about domestic abuse, you may move on to the next question or choose not to complete the questions. You will not be penalized in any way for the way you answer the questions.

The questions below refer to a relationship with a "partner." For purposes of this screen "partner" can include any of the following: a spouse or former spouse; an adult with whom you have or had a dating relationship, an adult with whom you have a child in common, an adult or minor family member, or an adult or minor with whom you reside or formerly resided. This is to acknowledge the broad circumstances in which domestic abuse can occur.

	Question	YES (if yes, when)		NO
		Current	Past	
1	Have you been in a relationship in which your partner has harmed you either physically or sexually? (Examples: punching, grabbing, pushing, choking, restraining)			
2	Have you ever been afraid that your partner might hurt you? (Examples: using looks, actions, gestures, smashing things, destroying property, abusing pets, displaying weapons)			
3	Has your partner made threats to physically harm you?			
4	Has your partner ever prevented you from leaving your home, traveling to work, or visiting family or friends?			
5	Has your partner ever refused to let you have money, made you ask for money, or took money from you against your will?			
6	Have you ever received services or lived in a shelter for victims of domestic abuse?			

Thank you for your patience and cooperation. Please return this to your FEP or case worker.

If you have any questions about this or would like any information about domestic abuse or domestic abuse providers, please ask your FEP or case manager.

WISCONSIN DEPARTMENT OF WORKFORCE DEVELOPMENT

Screen 2

Note to Interviewer: Screen 2 is only required when the Functional Screen indicates it is necessary.

Interviewer Narrative: *First, I want to ask you some questions about school and how you learn things.*

- | | | |
|--|-----|----|
| 1. Have you had any problems learning in grades six through eight? | Yes | No |
| 2. Is it hard for you to work from a test book to an answer sheet? | Yes | No |
| 3. Do you have trouble working with numbers in a column? | Yes | No |
| 4. Do you have trouble judging distances? | Yes | No |
| 5. Does anyone in your family have learning problems? | Yes | No |

A. Number of "yes" responses = _____

- | | | |
|---|-----|----|
| 6. Have you had any problems learning in grades one through five? | Yes | No |
| 7. Do you have trouble mixing up math signs (=/x)? | Yes | No |

B. Number of "yes" responses multiplied by 2 = _____

- | | | |
|--|-----|----|
| 8. Do you have trouble filling out forms? | Yes | No |
| 9. Do you have trouble memorizing numbers? | Yes | No |
| 10. Do you have trouble remembering how to spell words you know? | Yes | No |

C. Number of "yes" responses multiplied by 3 = _____

- | | | |
|--|-----|----|
| 11. Do you have trouble taking notes? | Yes | No |
| 12. Do you have trouble adding and subtracting small numbers in your head? | Yes | No |
| 13. Were you ever in a special program or given extra help in school? | Yes | No |

D. Number of "yes" responses multiplied by 4 = _____

Total (A + B + C + D) = _____

Referral Information: If total is more than 12 refer to a psychologist, or DVR or private vocational rehabilitation agency.

Interviewer Narrative: *Now, I'd like to ask you a few questions about how you are dealing with things that may be bothering you.*

- | | | |
|---|-----|----|
| 14. Do you have trouble remembering details from your past? | Yes | No |
| 15. Do you feel alone or isolated from people in your life? | Yes | No |
| 16. Do you have trouble falling asleep or staying asleep? | Yes | No |
| 17. Are you jumpy? | Yes | No |
| 18. Do dreams or past memories cause you problems at work or in daily life? | Yes | No |
| 19. Have you ever lost your appetite for two or more weeks? Or, have you ever lost or gained as much as two pounds a week for several weeks without trying? | Yes | No |
| 20. During the past month have you felt afraid for no reason? | Yes | No |

Referral Information: Any two "yes" responses on questions 14-20, refer to a psychologist or DVR or private vocational rehabilitation agency.

Interviewer Narrative: *Now, I would like you to look at this piece of paper.*

Note to Interviewer: Please give response sheet to participant.

Interviewer Narrative: *Pick the answer for each question that is closest to how often you think the situation has happened to you.*

Note to Interviewer: Please circle the appropriate response for each of the questions.

	All of the time	Most of the time	A good bit of the time	Some of the time	Almost none of the time	None of the time
21. <i>How much of the time during the last month have you been a very nervous person?</i>	1	2	3	4	5	6
22. <i>How much of the time during the last month have you felt calm?</i>	6	5	4	3	2	1
23. <i>How much of the time during the last months have you felt down hearted and blue?</i>	1	2	3	4	5	6
24. <i>How much of the time during the last month have you been a happy person?</i>	6	5	4	3	2	1
25. <i>How much of the time during the last month have you felt so down in the dumps that nothing could cheer you up?</i>	1	2	3	4	5	6

Referral Information: 1. Add up each of the numbers circled

Question 21 = ____

Question 22 = ____

Question 23 = ____

Question 24 = ____

Question 25 = ____

Total = ____

2. Divide up the total score by the number of questions answered (usually it would be 5).

Average score = ____

3. If the average score is less than 2.9, refer to a psychologist, or DVR, or private rehabilitation agency.

Interviewer Narrative: I would like to take a few more minutes and ask you some questions about any head injury you may have had.

26. <i>Have you ever had a significant blow or injury to your head?</i>	Yes	No
---	-----	----

Note to Interviewer: If answer is "no," proceed to the next set of questions beginning with question 29.

If answer is "yes," proceed to question 27 below.

27. <i>Did you ever pass out for 15 minutes after a blow or injury to your head (for example after an accident or a fall)?</i>	Yes	No
--	-----	----

Note to Interviewer: If answer is "no," proceed to the next set of questions beginning with question 29.

If "yes," proceed to question 28 below.

28. *After the blow and you passed out, did you experience any significant changes in:*

a. <i>Memory</i>	Yes	No
b. <i>Mood</i>	Yes	No
c. <i>Relationships</i>	Yes	No
d. <i>Ability to carry on as usual on a daily basis</i>	Yes	No

Referral Information: If response to question 28 is "yes," refer to a psychologist, or DVR or private vocational rehabilitation agency.

Interviewer Narrative: *Finally, I'd like to ask you a few questions about your drug and alcohol use.*

- | | | |
|--|-----|----|
| 29. During the past year, has a friend or family member ever told you that they were worried about you or your behavior? | Yes | No |
| 30. During the past year, has a friend or family member ever told you that they were worried about your drinking or drug use and suggested that you cut down? | Yes | No |
| 31. Do you sometimes feel the need to cut down on your drinking or drug use? | Yes | No |
| 32. Do you sometimes take a drink, use a drug, or get high in the morning when you first get up? | Yes | No |
| 33. During the past year, has a friend or family member ever told you about things you said or did while you were drinking or using drugs that you could not remember? | Yes | No |
| 34. During the past year, have you ever felt guilty or ashamed after drinking or using drugs? | Yes | No |
| 35. During the past year, have you ever failed to do what was expected of you because of drinking or using drugs? | Yes | No |
| 36. During the past year, have you ever lost friends, a girlfriend, boyfriend, spouse, or the custody of a child because of your drinking or drug use? | Yes | No |

Referral Information: One "yes" response to questions 30-36, refer to an AODA service provider.

Interviewer Narrative: *Thank you for your answers and your patience.*

Note to Interviewer: Please give this list to participant while you ask the questions.

Scoring Sheet for Screen 2 Questions 21 – 25

All of the time

Most of the time

A good bit of the time

Some of the time

Almost none of the time

None of the time

Section I Family Needs

Interviewer Narrative: *The following questions have to do with any family members in your household that may have special needs due to a disability or medical condition . This information will help me determine if special consideration must be given when you are assigned to work, training or other activities.*

Note to Interviewer: For any YES responses, the Summary should include name, age and relationship of family member and an explanation of the problem or special need described by the participant.

Do you have a family member in your household with special needs that make it difficult for you to work?

☐ YES ☐ NO

Summary:

Do you have a family member in your household with medical problems?

☐ YES ☐ NO

Summary:

Do you have a family member in your house hold who is frequently suspended from school or work (or who gets in other trouble) due to behavioral problems?

☐ YES ☐ NO

Summary:

Do you have a child that misses school frequently?

☐ YES ☐ NO

Summary:

Do you have a child who is involved with child welfare services?

☐ YES ☐ NO

Summary:

Section I – Family Needs Summary:

Section II – Child With Special Needs

Child Part A. Background

1. *Do you have any concerns about your child's health or development?*
☐ YES ☐ NO

If yes, what are these concerns?

2. *Please tell me if your child receives services from any of the following programs:*

Interviewer: If response is YES for any of these programs, follow-up by asking: *Please tell me the contact name, phone number and why your child is seen by this program.*

☐ Birth-to-Three

Contact Name:
Contact Phone:

Comments

☐ Family Support

Contact Name:
Contact Phone:

Comments:

☐ Exceptional Education Needs
(Special Education-Public Schools)

Contact Name:
Contact Phone:

Comments:

☐ Children with Special Health
Care Needs

Contact Name:
Contact Phone:

Comments:

☐ Any Other Programs?

Contact Name:
Contact Phone:

Program Name: _____

Comments:

Interviewer: If response was YES to any of the programs, follow-up by asking: *Which of these programs that we just talked about knows most about your child's situation and needs?*

Interviewer: If the answer is YES to question 1 or any YES responses to question 2, please continue to **Part B**.

If the answer is YES to question 1, but NO to 2, referral information should be provided for services in the local community.)

Child Part B: Health And Developmental Needs

1. *Has your child been diagnosed with a specific medical condition?*

☐ YES ☐ NO

If yes, what is the diagnosis?

2. *How often does your child receive program services and/or medical treatment?*

Program Services

☐ Daily
☐ 3 to 4 times per week
☐ 1 or 2 times per week
☐ 3 or 4 times per month
☐ 1 or 2 times per month
☐ less than 1 time per month
☐ Not at all

Medical Treatment

☐ Daily
☐ 3 to 4 times per week
☐ 1 or 2 times per week
☐ 3 or 4 times per month
☐ 1 or 2 times per month
☐ less than 1 time per month
☐ Not at all

Comments:

3. *How often does your child see a physician?*

☐ every week
☐ every month
☐ more than once a year
☐ less than once a year

Physician's contact information (physician's name, clinic name and phone number):

Type of physician or specialty:

When was your child last seen? Why?

4. *Does your child receive therapeutic or educational services for health care needs such as :*

- | | |
|---|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Mental Health Issues |
| <input type="checkbox"/> Educational services | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Other _____ |

What is your role in these services and follow up? How often are you involved in this role?

Child Part C: Daily Living Needs

1. *Does your child have needs (other than what is expected for his/her age) for daily supervision/assistance, such as:*

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Communicating |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Behavior |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Forming Relationships/Friendships |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Toileting |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Other _____ |

Comments:

2. *Does your child have need for medical/health treatments, such as:*

- | |
|--------------------------------------|
| <input type="checkbox"/> G-tubes |
| <input type="checkbox"/> Suctioning |
| <input type="checkbox"/> Tracheotomy |
| <input type="checkbox"/> Medicines |
| <input type="checkbox"/> Other _____ |

Who administers to these needs above, and how often?

What is your role in caring for your child with these treatments and how often is this done?

3. *Does your child require assistive devices for communication, such as:*

- | |
|---|
| <input type="checkbox"/> Computer |
| <input type="checkbox"/> Picture Cards |
| <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Hearing aides or other assistive listening devices |
| <input type="checkbox"/> Other talking devices |

What is your role in using these devices and how often is this done?

4. Does your child require supervision/assistance with mobility, such as:

☐ Crutches
☐ Braces
☐ Wheelchair
☐ Special Transportation Monitor
☐ Other _____

What is your role in meeting your child's needs with these assistive devices and how often?

5. Does your child receive home health care or other personal care services?

☐ YES ☐ NO

If yes, please describe the services.

6. *Is your child's care consistent from week to week or does it change frequently with circumstances (e.g., appointments, health status)?*

7. Are you ever contacted by the school to take your child home due to behavior problems or physical or health problems.

☐ YES ☐ NO

If yes, how frequently?

8. *Looking at this scale, please tell me the number between one and ten that most accurately describes your routine based on your child's special needs.*

1	5	10
Regular and Stable		Totally Unpredictable

Child Part D: Child Care Needs

1. *Does your child have any health or behavioral problems that you believe would not allow placement in child care?*

☐ YES ☐ NO

Comments:

2. *Does your child require any special accommodations from a child care provider?*
☐ YES ☐ NO

Comments:

3. *Is the child spending part or all of their day in special programming?*
☐ YES ☐ NO

If yes, please tell me the schedule.

4. *Has your child ever been, or is your child currently placed in group or family child care?*
☐ YES ☐ NO

Comment:

5. *Have you ever had problems finding child care?*
☐ YES ☐ NO

Comment:

6. **Interviewer:** Review with participant the Health and Development Needs from Part B and response to question 3 of this section.

Do you foresee any problems coordinating child care and the other programs identified in question 3, or services described in Part B?

☐ YES ☐ NO

Comments:

Section II - Adult Family Member With Special Needs

Adult Part A: Health Needs

1. *Has this family member been diagnosed with a specific medical condition?*

☐ YES ☐ NO

If yes, what is the diagnosis

2. *Does this family member receive program services and/or medical treatment (example: DVR, Community Integration Program, Community Supported Living Arrangements, SSI or SSDI)?*

☐ YES ☐ NO

If yes, what type of services is this family member receiving?

3. *How often does this family member receive program services and/or medical treatment?*

Program Services	Medical Treatment
<input type="checkbox"/> Daily	<input type="checkbox"/> Daily
<input type="checkbox"/> 3 to 4 times per week	<input type="checkbox"/> 3 to 4 times per week
<input type="checkbox"/> 1 or 2 times per week	<input type="checkbox"/> 1 or 2 times per week
<input type="checkbox"/> 3 or 4 times per month	<input type="checkbox"/> 3 or 4 times per month
<input type="checkbox"/> 1 or 2 times per month	<input type="checkbox"/> 1 or 2 times per month
<input type="checkbox"/> less than 1 time per month	<input type="checkbox"/> less than 1 time per month
<input type="checkbox"/> Not at all	<input type="checkbox"/> Not at all

Comments:

4. *How often does this family member see a physician?*

☐ every week
☐ every month
☐ more than once a year
☐ less than once a year

Physician's contact information (physician's name, clinic name and phone number):

Type of physician or specialty:

When was this family member last seen? Why?

5. Does this family member receive therapeutic services for health care needs such as :

- | | |
|---|---|
| <input type="checkbox"/> Physical Therapy | <input type="checkbox"/> Mental health issues |
| <input type="checkbox"/> Vision | <input type="checkbox"/> Occupational Therapy |
| <input type="checkbox"/> Hearing Impairment | <input type="checkbox"/> Speech Therapy |
| <input type="checkbox"/> Other _____ | |

What is your role in these services and follow up? How often are you involved in this role?

Adult Part B: Daily Living Needs

1. Does this family member have needs for daily supervision/assistance, such as:

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Dressing | <input type="checkbox"/> Communicating |
| <input type="checkbox"/> Eating | <input type="checkbox"/> Behavior |
| <input type="checkbox"/> Mobility | <input type="checkbox"/> Forming Relationships/Friendships |
| <input type="checkbox"/> Breathing | <input type="checkbox"/> Toileting |
| <input type="checkbox"/> Sleeping | <input type="checkbox"/> Other _____ |

Comments:

2. Does this family member have need for medical/health treatments, such as:

- | |
|--------------------------------------|
| <input type="checkbox"/> G-tubes |
| <input type="checkbox"/> Suctioning |
| <input type="checkbox"/> Tracheotomy |
| <input type="checkbox"/> Medicines |
| <input type="checkbox"/> Other _____ |

Who provides the primary care for these needs, and how often?

What is your role in caring for this family member with these treatments and how often is this done?

3. Does this family member require assistive devices for communication, such as:

- | |
|---|
| <input type="checkbox"/> Computer |
| <input type="checkbox"/> Picture Cards |
| <input type="checkbox"/> Sign Language |
| <input type="checkbox"/> Hearing aides or other assistive listening devices |
| <input type="checkbox"/> Other talking devices |

What is your role in using these devices and how often is this done?

- ☐ Crutches
☐ Braces
☐ Wheelchair
☐ Special Transportation Monitor
☐ Other _____

-
-
-
-

-
-
-

- 1 5 10
Regular and Stable Totally Unpredictable
